Allcare Agency Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Allcare Agency is a domiciliary care agency that provides personal care to people living in their own homes, including older adults and younger disabled adults. At the time of our inspection the service was supporting 14 people.

People's experience of using this service:
The provider had failed to ensure that people were supported in a safe way. Risk assessments did not identify and mitigate individual risk; medicines were not being managed safely; recruitment practices did not ensure staff were suitable to support vulnerable people and there was no recording or analysis of accidents and incidents. We also found that the systems in place to protect people from harm and abuse were inadequate. This placed people at risk of harm or unsafe care.

There were significant shortfalls regarding staff training, the induction procedures for new members of staff and support through supervisions. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems did not support this practice.

The service lacked a consistent approach to people and their relatives being involved in the care and support they received, and the service was failing to ensure it promoted a culture and equality and diversity. Care plans remained inconsistent and did not always guide staff to provide person-centred care.

We found that the systems in place to manage complaints and end of life care were insufficient.

The quality assurance systems were inadequate as they had not identified the shortfalls we found during our inspection and did not ensure people were always kept safe. We found that staff, including the registered manager failed to demonstrate they were providing care and support that was safe, caring or effective. This put people at continued risk of harm.

However, people and their relatives felt the care and support they received was person-centred, and they trusted staff to look after them.

Rating at last inspection:
At the last inspection the service was rated Inadequate (published: 4 December 2018).

At that time, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were related to Safe care and treatment; Fit and proper persons employed; Staffing; Person-centred care; Good governance. We also found one breach of the Registration Regulations Act 2009, as there was a failure to notify the Care Quality Commission (CQC) of incidents that affected people in receipt of a regulated activity.

During this inspection, we found the overall rating had not improved and an additional key question had changed from requires improvement to inadequate. We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were related to Safe care and treatment; Fit and proper persons employed; Staffing; Person-centred care; Need for consent; Safeguarding Service Users from abuse and improper treatment and Good governance.

This service has been rated 'inadequate' at the last two inspections.

Why we inspected:
This was a planned inspection based on the rating at the last inspection.

Enforcement:
Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

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Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was 'older people'.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger adults with physical and learning disabilities. At the time of our inspection the service was providing care and support to 14 people.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 36 hours' notice of the inspection visit because it is small, and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We also spoke with the local authority commissioners and other health and social care providers.

Providers are required to send us key information about their service, what they do well, and improvements

they plan to make. This information helps support our inspections. This is called a Provider Information Return form and the service had submitted this. This formed part of our inspection planning.

During the inspection, we spoke with two people who used the service and ten relatives. We also spoke to the registered manager. We reviewed six people's personal care records, four staff records, staff rotas, medicine administration records and other records relating to the management of the service such as health and safety records and training records.

After the inspection, we spoke to three care staff.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management:

- At the previous inspection on 23 October 2018, we identified a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. People's risk assessments did not identify people's specific risks, and these were not reviewed on a regular basis. During this inspection, we found this breach had not been addressed.
- We looked at six people's risk assessments and found they did not always reflect the medical conditions they lived with and there was little or no information about risks relating to these specific conditions. Therefore, staff were unaware of what risks were associated with people's condition and were not guided on how to manage or mitigate associated risks to keep people safe.
- For example, one person had a medical condition characterised by progressive degeneration of muscles. There was no risk assessment in place that detailed the progressive nature of this condition can lead to heart or respiratory problems. A second person's risk assessment was blank under, 'medical condition' but we saw an email from the person to the registered manager identifying they had Parkinson's Disease, Depression and Carpal Tunnel amongst other conditions. As the service had failed to assess people's risks they could not ensure people received care and support that kept them safe from harm.
- Staff told us they would read the care files for guidance on how to support people. However, staff were not provided with enough instructions to guide them on how to keep people safe when faced with these risks. For example, we saw that one person might shake due to anger. There was no instruction for what staff were to do in this situation.
- The provider had failed to assess individual risk to people to ensure they received care and support that kept them safe from harm. This showed a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:

- At the previous inspection on 23 October 2018, we identified a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. Medicines were not being managed safely as we found people had not received their medicines in a safe way. During this inspection, we found this breach had not been addressed.
- We found discrepancies between different documentation in people's care files regarding their medicines support needs; some people's records said they took medicines while other records within their care file stated they did not. It was therefore not clear what support people required.
- The policy stated the information in Medicine Administration Records (MAR) should contain, what the medicine is being prescribed for, when the medicine should be given, what the dose is and how it should be taken. We found MAR did not state what the medicine was being prescribed for, nor how it should be taken. This meant that there was a risk staff may not know how to administer medicines in a safe way.
- People's MAR had unexplained gaps which indicated their medicines had not been given. One person had

missed a medicine on two occasions; their daily records said the person was asleep at the time. This information was not captured on the MAR and there were no notes to indicate that this medicine had been attempted to be given at any other time. A second person had not received their medicine on one occasion; there were no records to account for this gap or any action that had been taken. The records did not identify what the risks of not taking these medicines were. We spoke to the registered manager who told us they did not know of this error, or the risks of not taking these medicines.

● The registered manager had begun weekly MAR audits that may have identified the shortfalls we found. However, records confirmed that MAR audits has not been completed since 18 March 2019.

● Records confirmed that only one out of eleven staff members had completed medicines training. Following the inspection, we were provided with a certificate of attendance for medicines training; this shows that nine out of eleven staff members have completed medicines training.

● The provider had failed to assess people's medicines support needs and to have sufficient systems in place to enable staff to support people with their medicines in a safe way. This showed a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● However, people and their relatives told us if medicines were being administered, a record was made.

Learning lessons when things go wrong:

● At the previous inspection on 23 October 2018, we identified a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. Accidents and incidents were not being reviewed and action taken to minimise re-occurrence. During this inspection, we found this breach had not been addressed.

● We were advised there had not been any accidents or incidents since our last inspection, or since the service registered on 25 May 2011.

● We spoke with three staff who gave us examples of when there had been incidents of falls for people using the service; these staffs advised these had been recorded. However, there were no forms that had been completed to review these incidents and learn from lessons to minimise the risk of re-occurrence.

● This demonstrated that the service did not effectively monitor the care and support provided to people ensuring lessons could be learnt to minimise risks and ensure people were safe at all times. This showed a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment:

● At the previous inspection on 23 October 2018, we identified a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and Proper Persons Employed. Staff were not always recruited in a safe manner and people were not always cared for by staff who were suitable for the role. During this inspection, we found this breach had not been addressed.

● At the last inspection, we found one staff had been employed where their criminal record check had stated conditions that may impact on providing safe care and treatment to people, and there was no evidence of this being reviewed or risk assessed by the registered manager. During this inspection, we found this had still not been risk assessed.

● We found one other staff member's criminal record check had conditions that may impact on providing safe care and treatment to people. This member of staff was providing care and treatment to people in their homes despite the provider not yet receiving references or risk assessing their criminal record check. This showed the systems in place could not ensure this staff was suitable to be supporting vulnerable adults. This meant people were at risk of harm as the service had not conducted sufficient checks to ensure staff were of good character.

● Following the inspection we received evidence that the service had received references for this new staff member and records to confirm that a risk assessment had been completed to ensure this staff member

was safe to provide care and support to people. This showed the systems in place at the time of our inspection could not ensure this staff member was suitable to be supporting vulnerable adults; however, the systems implemented following the inspection meant people were not at risk of harm as the service had conducted sufficient checks.

● The provider had failed to ensure that recruitment procedures were robust in ensuring that all staff were of good character and had the skills or competence required for their role. This showed a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:

● The systems in place did not ensure people were protected from the risk of abuse.

● Staff did not always demonstrate a clear understanding of how to manage safeguarding alerts. One staff member told us, "[I would] speak to the manager; I wouldn't necessarily put it in the report." The registered manager said, "[I] put myself on safeguarding course. Half of it was rubbish and half of it was over the top."

● The service had a safeguarding policy in place that had not been reviewed since 2017 and it referred to the wrong local authority. Staff had not been provided with the correct policies and procedures to follow, which meant people may not receive appropriate care and support to keep them safe.

● Records confirmed only six out of eleven staff had completed safeguarding training. There was a risk they may not know how to recognise abuse and who to report to.

● The service did not keep a record of any potential safeguarding incidents and there was no way of tracking trends and outcomes of people affected by potential abuse.

● There were inadequate systems in place to safeguard people from the risk of abuse. This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding Service Users from abuse and improper treatment.

● However, people and their relatives told us that they felt safe in the company of their carers. One relative said, "Yes, [person] is definitely safe."

● Following the inspection we received records to confirm that ten out of eleven staff had completed safeguarding training.

Staffing:

● The provider used an electronic system to ensure that there were enough staff to meet people's needs. If staff were unable to attend work, then the system could identify who else was available to provide care and support to people.

● People and their relatives told us staff arrived on time and they received care and treatment from the same staff ensuring there was continuity of care. One relative said, "[Person] often sees the same people. They know how [person] likes things done. No missed calls. Always turn up on time or warn me if they are going to be late." This meant people could depend on the service to provide care and treatment in a timely manner, with familiar staff.

Preventing and controlling infection:

● People and their relatives told us that staff always wore gloves and aprons as appropriate.

● The service had an infection control policy. People's care plans guided staff to wash their hands before and after tasks. One staff said, "Make sure you wear your gloves and apron."

● Records confirmed staff were taking appropriate measures to protect people from cross infection. One spot check noted personal care items were appropriately disposed of.

● We saw there were gloves, aprons and hand wash available for staff in the office.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience:

- At the previous inspection on 23 October 2018, we identified a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. We found staff did not always receive an induction, training and supervision to enable them to provide effective care and support to people. During this inspection, we found this breach had not been fully addressed.
- We reviewed individual staff training records and found that not all staff had completed essential and relevant training. For example, none had completed training on how to support people living with dementia or a stroke, and only eight out of eleven members of staff had completed training in Parkinson's. Staff were providing support to people affected by these conditions, which meant people were at risk of receiving inadequate care and support. When we fed this back, the registered manager told us, "Maybe I haven't pushed as much as I should, [staff] don't want to do [training]."
- We spoke to staff about specific training for Parkinson's, dementia and stroke awareness; one staff said, "Not done these no, they have always been on the computer but not done them."
- We found there was no guidance available to tell us how often training should be done. The registered manager advised there was no system in place to monitor what training staff had or had not completed and when training was due. There was no training matrix in place; the registered manager said, "I can't do a matrix." The registered manager also told us that staff did not have to complete a set list of training before being able to provide care and support to people. This meant the service could not be sure staff had sufficient and relevant knowledge to ensure they could keep people safe and meet their needs.
- This demonstrated that staff were not supported to ensure they had the suitable skills and knowledge to deliver effective care and support to people.
- Following the inspection we received records to confirm that ten out of eleven staff had completed training on dementia, six on stroke awareness and nine on Parkinson's. This shows that whilst not all staff have completed training in relevant areas, the service was working towards ensuring the staff were provided with the adequate skills to provide effective and safe care and support.
- The service had recently recruited one new staff member; an induction schedule was in place. However, it had not been completed and did not accurately reflect what the new staff would be doing. For example, there was no mention of the new staff shadowing experienced staffs, but we had been advised this staff had already done two days shadowing. There were no records in place to evidence this.
- Following the inspection, the registered manager sent us a new induction schedule. However, this document did not provide assurances that the shortfall had been met as it showed that most objectives had been achieved in one day, and the staff had completed manual handling training and shadowed an experienced member of staff on the same day.
- The registered manager was not clear if staff received supervision every three or six months. We were told

that all staff had recently received a supervision; however, the registered manager was only able to find two out of eleven staff supervision records. There was no system in place to ensure supervisions were scheduled.

● We spoke to staff about whether they felt supported and received regular supervisions. One staff said, "It was okay, my next one isn't scheduled." Another staff told us, "I have done it a few times, over a few years. I don't know when our next one is."
● The provider had failed to ensure staff received adequate training and support and there was insufficient evidence to show that staff were able to carry out their role effectively. This demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● However people and their and relatives felt staff understood their needs and were well trained. One relative told us, "Yes, [staff] are just so capable."

Ensuring consent to care and treatment in line with law and guidance:
● There were no individual consent forms in place for people to confirm they had consented to receive care and support.
● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found that they were not.
● We looked at six people's care files and saw that Mental Capacity Act 2005 (MCA) Assessments had been completed. However, these were not time and decision specific and did not determine people's capacity for specific topics. Furthermore, where people had been assessed as not being able to make decisions for themselves and where they needed others to make those decisions on their behalf, best interest decisions had not been recorded.
● Staff did not demonstrate an understanding of the MCA, or how to obtain consent from people before providing care and treatment. One staff said, "I haven't had full training on this, I think this is just common sense. I don't deal with anyone who has mental health problems. I don't really know."
● Records confirmed that no staff had completed MCA training.
● This shows the service was not always providing care and support in line with the MCA. As a result, people were at risk of having decisions made without their consent and not in line with their best interests. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.
● However, people and their relatives felt staff sought consent before carrying out new tasks. One relative said, "They communicate with [person] which is lovely, because [person] can't really speak now. They are always telling [person] what is going to happen, so there are no surprises."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● The service received a 'Service User Placement Agreement' from the local authority but this document contained no information about people's individual care and support needs. However, the service did not complete pre-admission assessments to identify people's support needs and determine if they can support people effectively. This showed that the service was not assessing people's needs and choices to ensure they could deliver effective care and support.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support:
● There was no evidence of engagement with other services to offer holistic care and support in line with

people's needs.
● We reviewed individual care plans and found that contact details of other health and social care professionals were not always completed; however, we saw from individual care records that people would require support from other services. This meant that staff may not know who to contact if people were not well.
● One staff said, "We do if need be, [they] do their own thing. We don't deal with professionals."
● However, one relative told us, "[Staff] pick up quickly if [person's] health changes. And they always step in if I am not well." Another relative said, "[Staff] will come in early if he needs to go to hospital. They really try to adapt to changing needs."
● This showed that the service varied in its approach to working in a collaborative manner to provide effective care and treatment for people.

Supporting people to eat and drink enough to maintain a balanced diet:
● People's care files asked questions about preferences and support needs at mealtimes, including whether people could prepare their own food, if they had any special dietary needs and what their appetite was like.
● One staff said, "We always write for a few people what their food intake is, if they have had a bowel movement. The ones who we give medicines too, we record this for them too."
● This showed that the service worked well to ensure people maintained a balanced and personalised diet.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

RI: People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity:

- People told us that staff were caring. One person said, "I could not wish for better, they are like family." A relative said, "Yes, [person] is always smiling when [staff] arrive."
- Staff were able to give examples of how they provided kind and compassionate care. One staff said, 'We know [person] likes to look out the garden so we put [person] in [their] front room." Another staff told us, "I just want to make the clients laugh and have a joke."
- However, when we spoke to the registered manager about a person's care plan that said, '[Person] depressed always wants to die' they told us this person's mental health did not need to be assessed due to their disability. There was no information provided about how staff can support this person. This demonstrated the registered managers lack of understanding about people's wellbeing and a lack of dignity and respect.
- Staff did not demonstrate an understanding of how to promote equality and diversity. One staff member said, "I haven't had training on this." Another staff member told us, "Not too sure. Don't know these words."
- Within individual care plans we did not see any evidence of people's protected characteristics being discussed. For example, there was no record of people's sexuality or relationships or if they had any cultural or religious needs that needed to be taken into consideration.
- The service did not have an equality and diversity policy in place. The registered manager advised they were in the process of transitioning to a new system but had not yet used it.
- This showed that the service did not have systems in place to ensure staff were working in line with best practice to support people's individual preferences and protect them from potential discrimination.

Supporting people to express their views and be involved in making decisions about their care:

- One relative told us that there was a care plan in place, and that this had been reviewed recently.
- Staff had mixed responses about whether care plans were reviewed with people and their relatives. One staff member said, "I don't know if they happen. Never heard of them." Another member of staff told us, "Every 3-6 months it depends what [people] want. They have all been done so it is due when [people] want it next."
- The registered manager told us, "[Care plans] all been updated, all people have been visited and have been updated in line with current paperwork. I hope the information is in there."
- However, we reviewed people's care plans and found there were not always records of people and their relatives being involved in making decisions and reviewing their care package. Two care plans had no signatures to evidence people had read and agreed with the content. One person had signed a care record that had details about a different person; the registered manager confirmed when reading the care plan to this person before asking them to sign it, they had not read this part. This meant the person did not know they were signing an incorrect care plan.

● This showed that the systems in place did not always ensure people and their relatives were consulted and therefore their care and support may not have been tailored to their needs and preferences.

Respecting and promoting people's privacy, dignity and independence:
● People and their relatives told us that they were treated with dignity and respect. One person said, "Of course [staff] treat me with dignity and respect. They seem to be very considerate."
● One staff said, "If they want a wash or a shower, we respect their wishes. Dignity is privacy for certain things like personal care."
● Records confirmed staff were respecting people's privacy and maintaining their dignity. One spot check noted, '[Staff] tells [person] what they are doing, puts towel over to protect dignity.'
● People told us they were supported to be as independent. One person told us, "[Staff] really encouraged me to be as independent as possible. But they do understand how to look after me."
● Staff were able to give examples of where they supported people to remain independent. One staff said, "[Person] wants to still walk and we support [person] with this."
● Records confirmed staff were supporting people to be independent. One spot check noted, 'We encourage to walk and hold onto the frame.' One person's care plan said, 'Help to wash [person's] back and legs [person] will wash the rest.'

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- At the previous inspection on 23 October 2018, we identified a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care. Individual care plans and records did not evidence the service was working in a person-centred way in line with best practice. During this inspection, we found this breach had not been fully addressed.
- We continued to find inconsistencies; one person's care plan said, 'Not applicable' recorded for their likes and dislikes. Another person's care plan said they, 'Likes opportunity to talk,' but the registered manager later advised this person was unable to talk and their communication methods were not recorded. A third person's care file recorded they were weak on the right side of their body and then further on said they were weak on their left side. As there were no further details it was difficult to know how people wanted to spend their time and how best to support them to maximise their health and wellbeing.
- Within some people's care plans we found improvements had been made regarding personal detail. Specifically, 'Assessments of need' were in place although they had not been completed for each person in full. One person's care plan said they were interested in holistic treatments including oils. Another person's care plan detailed the food and sports team they liked.
- This showed that people's care plans still do not fully reflect their preferences and guide staff on how to provide care that is person-centred and responsive. It was therefore difficult for staff to know how to support people appropriately and line with their personal preferences. This placed people at risk of not consistently receiving the care that they required or care that was person-centred. This demonstrates a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- However, people and their relatives felt the service provided care that was person-centred. One person said, "[Staff] definitely understand me. I would not be able to manage without them. One relative told us, "My [relative] is [specific age], so [registered manager] ensured the carer was around [the same] age."

Improving care quality in response to complaints or concerns:

- The service did not have a complaints policy in place at the time of our inspection. The registered manager advised they were in the process of transitioning to a new system but had not yet used it.
- The registered manager told us they did not keep a formal record of complaints. Instead they said if they received any negative feedback on the weekly forms they would meet with the person and make a note on this form. The registered manager told us they would not detail what had been done to resolve the complaint, only stating that it had been resolved. For example, one person had said on their feedback form, 'I feel a little rushed.' The registered manager had made a note to say they had spoken to this person and addressed this concern, but it was not clear what had been done to resolve this. The registered manager advised they did not share these complaints with the team as a learning and improvement opportunity.

Staff confirmed, "The registered manager deals with [complaints]."

● People and their relatives told us they had no reason to complain. Some relatives said that they occasionally raised issues with [registered manager] and had always been happy with the response.

● This showed that although people felt comfortable to make a complaint, the systems in place to evidence how complaints were managed were inadequate.

End of life care and support:

● The service was not supporting any people receiving end of life care at the time of our inspection but were likely to in the future. Staff confirmed, "Not at the moment, there was the [person] that passed away [four months ago]." Since our last inspection the service had provided end of life care to four people.

● Within people's care plans there were no records of end of life being discussed with people to ensure their wishes were known.

● Staff told us, and records confirmed that staff had not completed training in end of life care.

● The service did not have an end of life policy in place at the time of our inspection. The registered manager advised they were in the process of transitioning to a new system but had not yet used it.

● Following the inspection we received records to confirm that seven out of eleven staff had completed end of life training.

● This shows the systems in place to provide high quality end of life care were inadequate and meant that staff were not always and entirely equipped with the skills and knowledge to ensure people received the best quality of care when they were at end of life.

● However, we saw historic compliments from relatives whose loved ones had received end of life care.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility, Continuous learning and improving care. Working in partnership with others:

- At the previous inspection on 23 October 2018, we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. There were failures to embed quality assurance systems and ensure quality assurance methods were effective in identifying concerns and making improvements. During this inspection, we found this breach had not been addressed.
- We continued to find widespread shortfalls with risk assessments; medicines; safe recruitment practices and the analysis of accidents and incidents. We also found that the systems in place to protect people from harm and abuse were inadequate. There were ongoing shortfalls identified with staff training and induction and providing support through supervisions. The service was not working in line with the Mental Capacity Act 2005. We did not find a consistent approach to people and their relatives being involved in their care and the service was failing to ensure it protected people from discrimination. Care plans remained inconsistent and did not always guide staff to provide person-centred care and we found that the systems in place to manage complaints and end of life care were insufficient.
- The registered manager and staff told us they did not work in partnership with other health and social care professionals to ensure a culture of continuous learning and development. The registered manager told us they had registered with Skills for Care but had not attended any of the meetings.
- The registered manager told us staff attended monthly team meetings. We saw minutes from December 2018 and January 2019; the registered manager could not recall if there had been a team meeting since and there were no minutes available to evidence this. One staff member told us, "We have [only ever] done two." Therefore, there was no evidence that monthly team meetings were being held. As a result, staff were not provided with opportunities to discuss their role and wellbeing and ensure they were sharing relevant information that would enable them to provide safe and effective care and support.
- Records confirmed that the registered manager completed unannounced spot checks and direct observations of care being provided at home to ensure the care and support was of high quality. On all occasions staff were not wearing an ID badge. This meant people may not have been aware of who was providing care and support to them and may not have felt safe. We did not see an action plan in place to address this. The registered manager did not have a system in place to track any identified trends and findings from the spot checks and these were not discussed on a one to one level or with the team.
- The registered manager was not doing any other audits for example on care plans or staff training.
- The quality assurance processes were inadequate as they had not identified these shortfalls to ensure people were always safe.
- This shows that the provider had failed to ensure there were effective systems and process to assess,

monitor and improve the quality of care provided by the service. This demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our previous inspection we had identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Registration Regulations Act 2009. At this inspection we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which indicates the quality of care provided had worsened.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

● At the previous inspection on 23 October 2018, we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. The processes for feedback were not working effectively. During this inspection, we found this part of the breach had been addressed.

● One relative said, "The manager is very approachable if you have any issues." Another relative told us, "I panicked one day, and rang the manager at 8am. She turned up 10 minutes later to help me resolve the crisis. She is absolutely excellent."

● Following the previous CQC inspection, the service visited all people to complete a review of the services they received. We reviewed six people's reviews; they asked people if they were happy with their care plan, if they felt safe receiving care and support and if they were happy to continue receiving care and support. Mostly we found the feedback was positive.

● There were also weekly feedback forms in place for both people receiving care and support and for staff. We reviewed nine feedback forms from people and 12 feedback forms from staff; all comments were positive. One staff said, 'Keep up the team work, you're all great.'

● At the previous inspection on 23 October 2018, we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. There was a lack of confidence expressed in the registered manager, by people and their relatives with regards to the governance of Allcare Agency. During this inspection we found this part of the breach had been addressed.

● People and their relatives spoke highly of the registered manager. A relative told us, "It is definitely well organised. They will go the extra mile. They are a very good company. I am well satisfied." Another relative said, "It runs like a well-oiled machine. They have an [text system] which immediately alerts the carers to any issues."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

● At the previous inspection on 23 October 2018, we identified a breach of regulation 18 (Registration Regulations 2009), Notifications of other incidents. The registered manager did not know of their legal obligation to notify the Care Quality Commission of any incidents that affected people in receipt of a regulated activity. During this inspection, we found this breach had been addressed. We had received notifications of people who had passed away and were in receipt of a regulated activity.